



National Alliance on Mental Illness

NAMI Syracuse



Newsletter

SEPTEMBER/OCTOBER 2017

Meeting Schedule

NAMI Syracuse - Support & Sharing Meeting

Third Tuesday of each month, 7:00pm

AccessCNY, 420 East Genesee Street, Syracuse 13202

(parking and entrance in rear of building)

NAMI Syracuse Family Support Group

Second Wednesday of each month, 10:00am

NAMI Syracuse office, 917 Avery Avenue, Syracuse 13204

Events Calendar

- | | |
|--------------------|---|
| September 19, 2017 | Support & Sharing Meeting
7:00pm - AccessCNY |
| September 24, 2017 | 3rd Annual Harvest Hopela
Bishop Harrison Center, Syracuse
<i>(see page 3)</i> |
| October 4, 2017 | NAMI Syracuse Educational Conference
Rosamond Gifford Zoo, Syracuse
<i>(see page 3)</i> |
| October 11, 2017 | NAMI Syracuse Family Support
10:00am - NAMI Syracuse office |
| October 17, 2017 | Support & Sharing Meeting
7:00pm - AccessCNY |
| October 21, 2017 | L.O.V.E. Is The Answer Conference
A day long conference to improve police-community relations. For more information and/or to register go to:
lovesyracuse.eventbrite.com |
| November 8, 2017 | NAMI Syracuse Family Support
10:00am - NAMI Syracuse office |

NAMI Syracuse is a not-for-profit, self-help organization of active and concerned families and friends of people who suffer from serious and persistent psychiatric illnesses, most commonly schizophrenia, bipolar disorder (manic depression), and severe depression.

CARING

SHARING

EDUCATION

ADVOCACY

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MESSAGE FROM THE PRESIDENT

Dear Members:

It was a blink and miss sort of summer here in CNY. For those of you who don't like the heat, you are right where you belong! Some philosophers or spiritual teachers might say that we are always where we belong. But even if you have a hard time wrapping your head around that one, I'm sure you'll agree that we are always physically where we are - even if our mind and spirit isn't. But what happens when mind, body, and spirit are truly one? What happens when we are fully present, open, and accepting? When mind, body, and spirit collide, we have whole wellness. Whole wellness; do you wonder how to achieve this or what it even means?

This is exactly what we will be exploring at this year's NAMI Syracuse Educational Conference: **Mind, Body, Spirit: A Complete Approach to Mental Health & Wellness**. I'm hoping each of you will be physically present for this wonderful day of mindfulness and holistic approach to treating mental illness. Details are on page 3 of this newsletter. As in years past, we will be offering full scholarships for those who may not have the financial resources to attend. Please call the NAMI Syracuse office, 315-487-2085 to request a scholarship!

To help cover the cost of these scholarships, please join us on September 24th for our third annual **Harvest Hopela**, a wonderful event of food, music, and fun! Monies raised will be used for website improvement and maintenance, support groups, educational conferences, building maintenance and costs, insurance, staff, and the various office supplies needed for this newsletter. We have a scrumptious menu planned, marvelous musicians, and many splendid silent auction items. And if that's not enough adjectives for you: It's gonna be a humdinger of an awesomely excellent Hopela! Gather your friends and family and buy your tickets today! See details on page 3.

Enjoy the last few breaths of summer. See y'all on the 24th!

~~Karen

New Membership Structure as of July 2017

The National NAMI Board of Directors has voted to add a Household membership category to the membership structure and to increase the dues for Regular and Open Door memberships. These changes are effective as of July 1, 2017.

Household Membership	\$60.00
Regular Membership	\$40.00
Open Door Membership	\$ 5.00 (for those on limited income)

If you have not renewed your membership for 2017, please do so. We depend on you! If you are not sure that your dues are current, please call or e-mail the NAMI Syracuse office.

“When you do nothing, you feel overwhelmed and powerless. But when you get involved, you feel the sense of hope and accomplishment that comes from knowing you are working to make things better.”

NAMI Syracuse Officers

- Karen Winters Schwartz.....President
- Spencer Plavocos.....Vice-President
- Frank Mazzotti.....Treasurer
- Marla ByrnesRecording Secretary

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- Dr. Sunny Aslam
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- Dr. Mantosh Dewan
- Dr. Stephen Glatt
- Ann Canastra

For the latest happenings at NAMI Syracuse visit us on **Facebook** and **LIKE** our page.



[facebook.com/NAMISyracuse](https://www.facebook.com/NAMISyracuse)

Register your current Amazon account with NAMI Syracuse Inc. today by going to:

smile.amazon.com

and Amazon will donate 0.5% of the price of your eligible AmazonSmile purchases to NAMI Syracuse!

NAMI Syracuse Family Support Group

beginning Wednesday, October 11th, 10-11:30a.m., at the NAMI Syracuse Office.

All family members and friends of those living with mental health concerns are welcome to attend. Please call the office to sign-up and/or reserve your seat.

*light refreshments will be provided

*this group will run on the second Wednesday of every month from

10-11:30a.m.

Group Facilitators:

Ann Canastra & Marla Byrnes

NAMI Syracuse Educational Conference
Wednesday, October 4, 2017, Rosamond Gifford Zoo, Syracuse, 9:00am - 3:00pm
Mind, Body, Spirit: A Complete Approach to Mental Health & Wellness

~~presenters~~

Dr. Nasri Ghaly MD

Transcranial Magnetic Stimulation

Dr. Kelly Richards, Psy.D

Trauma & Integrative Therapies To Help

Dr. Renie Kehres Ph.D, MSN

Mindfulness & Meditation

Panel Discussion:

Kelly Springer - Nutrition

Renee Goot - Yoga

Rochette Withers - Spirit

Kim Sacco - Reiki, Essential Oils

Recipient of Gentile Advocacy Award:

Sheila Le Gacy, Director of the Family Support & Education Center, AccessCNY

- To register go to www.namisyracuse.org, click donate and indicate "conference registration" or call the NAMI Syracuse office to request a brochure.
- Some scholarships available, call 315-487-2085.
- Agencies can request a display table for cost of registration.
- Registration includes lunch.

Professional/Provider/Non-NAMI Member:

\$65.00

NAMI Member:

\$50.00

Student/Recipient of MH Services:

\$30.00

I hope you will consider supporting NAMI Syracuse by joining me at this awesome party. The third annual Harvest Hopela promises to be filled with great music, food, drink, and fun!

NAMI Syracuse made all the difference to me when our life was touched by mental illness. Thanks to your support, NAMI Syracuse will continue to be there for others in our community!

To purchase tickets go to our website, www.namisyracuse.org or call the office, 315-487-2085.

~~Karen

3rd Annual NAMI Syracuse Harvest Hopela

Sunday, September 24, 2017

Bishop Harrison Center

1342 Lancaster Avenue, Syracuse

4:00pm - 7:00pm



~~Food

~~Drinks

~~Entertainment

~~Silent Auction

\$60.00 per person

\$100.00 per couple

BRAIN STIMULATION COULD BE USED TO TREAT COGNITIVE DEFICITS FREQUENTLY ASSOCIATED WITH SCHIZOPHRENIA, ACCORDING TO A NEW STUDY FROM KING'S COLLEGE LONDON

Brain stimulation could be used to treat cognitive deficits frequently associated with schizophrenia, according to a new study from King's College London.

There is currently a lack of effective treatments and an urgent need for new interventions to address these problems in short-term memory and decision making, which are often severely impaired in people with schizophrenia. This can make it difficult for them to adequately plan, sustain necessary focus and attention, and remember information, which has a significant impact on day-to-day life.

These so-called cognitive deficits are not addressed by current antipsychotic medications, which only treat more widely recognized symptoms such as delusions and hallucinations. Researchers are therefore increasingly looking towards novel interventions and 'neuromodulation' has emerged as a promising new technique that can physically alter and improve the brain's functioning.

In the study, published in **Brain**, the researchers set out to use one particular form of neuromodulation -- transcranial direct current stimulation (tDCS) -- to see if they could undo some of these cognitive deficits in 28 people with schizophrenia. tDCS applies a small, painless electrical current across the brain through two electrodes applied to the scalp. Previous research has shown that this can improve the 'plasticity' of brain cells, making them more amenable to new inputs or training; in other words, it may make it easier for the brain to learn.

The researchers applied tDCS with tasks which specifically tapped into 'working memory' and 'executive functioning': the principle was that 'training' the brain in regions that are typically poorly performing in schizophrenia would be enhanced by the brain stimulation technique. An improvement in cog-

nitive performance was seen in those who had tDCS (and not in participants who received a 'sham' intervention), but only 24 hours after the brain stimulation was applied. This suggests that any changes in the brain and brain cells induced by neuromodulation may take some time to occur.

The researchers also ran brain imaging analyses to determine what was happening in the brain as these changes occurred. They found that tDCS was linked with changes in brain activity in regions associated with working memory and executive functioning, as well as in the cerebellum, a part of the brain increasingly recognized as important in learning.

Although an early study into neuromodulation and schizophrenia, this research is the first to suggest that tDCS could improve cognitive performance by changing activity in the brain. The study had a relatively limited sample size, so a larger, randomized controlled trial is now required to replicate these findings.

Dr Natasza Orlov, first author from the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King's College London, said: 'It's critical that we address some of the cognitive deficits seen in people with schizophrenia, as these determine how people do in real world settings, such as work and relationships. Anything that could positively address these could be incredibly helpful to our patients and their families.'

Professor Sukhwinder Shergill, senior author from the IoPPN at King's College London, said: 'Our study is the first of its kind and confirms that tDCS may help with some aspects of cognitive deterioration in patients with schizophrenia. Given the lack of treatments in this area, this is enormously important. Our brain imaging data is also helping to understand how this is happening, which will support future research in this field.'

Story Source: Materials provided by King's College London. Note: Content may be edited for style and length.

Journal Reference: 1.Natasza D. Orlov, Owen O'Daly, Derek K. Tracy, Yusuf Daniju, John Hodsoll, Lorena Valdearenas, John Rothwell, Sukhi S. Shergill. Stimulating thought: a functional MRI study of transcranial direct current stimulation in schizophrenia. *Brain*, 2017; DOI: 10.1093/brain/awx170

Syracuse Family Support Groups
Fall 2017

Support & Sharing Meeting for families and friends of persons with psychiatric disorders, facilitated by Sheila Le Gacy, is held on the 3rd Tuesday of each month at 7:00 p.m. at:

AccessCNY
420 East Genesee Street
Syracuse, NY

(between South Townsend Street and South State Street, next to the Onondaga County Sheriff's Department) Parking and entrance in the rear of the building.

NAMI Syracuse Family Support Group for families and friends of persons living with mental health concerns. This group will meet on the 2nd Wednesday of every month at the NAMI Syracuse office at 10a.m.

Begins: Wednesday, October 11th, 10 -11:30a.m.

NAMI Syracuse Office
917 Avery Avenue
Syracuse, NY

Facilitated by: Ann Canastra and Marla Byrnes

NAMI Homefront in collaboration with the Syracuse VA Medical Center and NAMI Syracuse will begin in the fall. For more information on this 6-week psychoeducational class, please call Ann Canastra at 315-425-4400 x52717.

For more information, call the NAMI Syracuse office @315-487-2085 or email us at: meetings@nami-syracuse.org

The start of this new season provides a wonderful opportunity for you to renew; it's a time to discover which parts of yourself you'd like to embrace and expand upon, and which parts of your summer skin you'd like to shed.



NEW SYRACUSE CLINIC AIMS TO EASE SHORTAGE OF MENTAL HEALTH CARE FOR KIDS

by James T. Mulder,
jmulder@syracuse.com

Even though he runs an agency that provides mental health and drug abuse treatment services, Jeremy Klemanski had trouble getting help for his own 15-year-old daughter when she was struggling with depression a year ago.

"There is nothing worse as a parent than knowing your child is suffering and you can't get them help," said Klemanski, president and CEO of Syracuse Behavioral Healthcare, SBH for short.

It took him weeks to get his daughter, Liliana, mental health care "because there were so many kids in our community already on line," Klemanski said.

He's hoping a new SBH clinic eliminates that wait for other parents and their children.

The clinic, which opened July 1, provides services for Central New Yorkers of all ages going through a mental health and/or substance abuse crisis. The clinic, part of a two-year federal demonstration project, allows SBH to offer services for the first time to children and teens. The agency is adding a 9,500-square-foot child and adolescent center in its clinic at 329 N. Salina St., Syracuse.

The clinic's goal is to provide care to children immediately, Klemanski said.

THE CONSENT DILEMMA

by Elyn Saks, *Politico, The Agenda*,
August 9, 2017

It's hard to keep mental-health patients on their medications. Would it help to let them say "no"?

Patient consent is an important principle in medicine, but when it comes to mental illness, things get complicated. Other diseases don't affect a patient's cognition the way a mental illness can. When the organ with the disease is a patient's brain, how can it be trusted to make decisions?

That's one reason that, historically, psychiatric patients were given very lit-

tle authority to make decisions about their own care. Mental illness and incompetence were considered the same thing. People could be hospitalized and treated against their will if they were considered mentally ill and "in need of treatment." The presumption was that people with mental illness - essentially by definition - lacked the ability to appreciate their own need for treatment.

In the 1970s, the situation began to change. First, the U.S. Supreme Court ruled that a patient could be hospitalized against his will only if he were dangerous to himself or others, or "gravely disabled," a decision that led to the de-institutionalization of most mental health care. Second, anti-psychotic medications came into wide use, effectively handing patients the power - on a daily basis - to decide whether to consent to treatment or not, simply by deciding whether or not to take their pills.

Today, even when hospitalized, psychiatric patients in about half of U.S. states have the right to refuse medication if they are competent. As a result, assessing competence and obtaining a patient's consent to be medicated has become a critical hurdle in the care of people with mental illness.

The truth is that many patients with psychiatric disorders don't want to be on psychotropic medications, and many patients, in and out of hospitals, refuse. Sometimes it's because they don't like the side effects, such as gaining weight, or feeling sluggish. Sometimes it's because once they feel better they don't think they need the meds anymore. And sometimes patients believe that successfully getting off of medication would prove they are not ill, and soothe the psychological injury of having an illness and needing treatment.

This can be a very frustrating situation for family or friends of those with mental illness. With the best of intentions, they may want to find a way to mandate treatment, so their loved one could get better. And residents of towns and cities where some of the untreated people with mental illness wind up living on the streets may think that it would also be in the best interests of those patients to somehow mandate treatment.

But as I can attest from personal experience, however paradoxical it may seem, the best way to increase the number of

mental patients who consent to treatment is to make it easier for them to refuse.

This is because if patients have a right to refuse, they have a chip with which to bargain with their doctor. And, indeed, there is evidence that when patients have input into the medication decision, they are likelier to adhere to their medication regimen. This is in part because they can provide valuable information about what works for them and what is most tolerable in terms of side effects. And it is also because, if they are involved in the decision, they are likelier to be committed to it - it is, after all, what they have chosen.

My own story helps explain why. I fell ill with schizophrenia when I was in my early 20s and was given a "very poor" and "grave" prognosis. I was expected to be unable to live independently, let alone to work. For about 10 years I made multiple efforts to get off medication, undertaking each effort with great gusto and failing miserably every time. My main motive was to prove I wasn't really mentally ill - that it was all some terrible mistake. My analyst eventually threatened to stop seeing me unless I stayed on my meds.

I decided to try one last time, and when that failed, I reconciled to being on the meds. And then something magical happened: My life got immeasurably better. I'm now a chaired professor at the University of Southern California Gould School of Law, happily married and with many friends.

When I look back on my journey, while I am sorry I didn't get smarter sooner, I know that forcing me to take the pills would have backfired and kept me locked in a power struggle over whether or not I was ill, instead of letting me come to terms with my illness in my own time and my own way.

I would hope that many patients will eventually end up in the same place I did. But even if they don't, giving them the choice is a necessary precondition to helping them address their mental illness. And if and when they do come around, they will be that much more committed to working with their doctors and staying healthy.

As a result, I believe it's important to expand the definition of competence so more patients with mental illness are deemed competent and retain control over

their treatment, and I'm working with colleagues at the University of California-San Diego School of Medicine on ways to do that.

Currently, psychiatrists often use something called the MacArthur capacity instruments to decide whether a psychiatric patient is competent to refuse care. Using MacArthur, doctors evaluate four items: a patient's understanding of her condition, her appreciation of its seriousness, her ability to use reason and her capacity for choice.

The "appreciation" piece is perhaps the most critical, evaluating a patient's ability to form correct beliefs about treatment and its risks and benefits. Far from most psychotic people being incompetent, on the MacArthur Appreciation scale, only about 23 percent of people hospitalized with schizophrenia scored "impaired."

But that's still too high.

Along with my collaborators at UCSD, I have designed a new appreciation test called the California Scale of Appreciation (the CSA). While MacArthur requires a patient to express roughly correct beliefs to pass the appreciation test, our standard would rule out only patently false beliefs. For example, under our CSA standard, a patient could refuse meds because of reasonably foreseeable side effects or risks, even if they are fairly uncommon. He could not refuse, however, if he believes he was helped by the meds in the past but a voice told him not to take them again or he would trigger a nuclear holocaust. Under this standard, our experts have rated just 8-13 percent of outpatients with schizophrenia incompetent - roughly half as many as MacArthur.

Another approach being tested by researchers at Stanford University is "enhanced consent" - protocols that review and summarize information in a user-friendly way. In these protocols, a video presentation may take the patient through the important elements of the treatment he or she is facing. These have been found to raise the mean performance of patients consenting to the same level as that of healthy comparison subjects. This approach shows that with proper supports, all but a small minority

of mental patients can make competent decisions about their treatment, making it more likely that more of them will get better with time.

The bottom line is that instead of designing new ways to force medication on patients, we need to put our efforts into finding new ways to help people want treatment so we don't have to use force. That's the best way to improve compliance and push the era of forced treatment deeper into the past.

~~Elyn R. Saks is a law professor at the University of Southern California Gould School of Law, a recipient of the MacArthur Foundation "genius" award and author of the memoir, *The Center Cannot Hold: My Journey Through Madness*.

What's the Difference Between OCD and OCPD

Obsessive-Compulsive Disorder (OCD) and **Obsessive-Compulsive Personality Disorder (OCPD)** are similar terms for two very different mental disorders. Because of the similarity in name, the two are often mistaken for the same thing. In order for people to receive the best possible treatment for what they're experiencing, it's important to know the difference between **OCD** and **OCPD**.

OCD is a mental illness that involves unwanted thoughts (obsessions) and/or actions (compulsions). Frequently, someone living with **OCD** experiences both. The intrusive obsessions are typically disturbing to the person and cause significant anxiety. He/she engages in repetitive actions or mental acts like counting in order to dispel the obsessions. These compulsions consume a significant amount of time, and together with the obsessions, can severely limit someone's life.

OCPD, on the other hand, is classified as a personality disorder. Personality disorders are long-term patterns of behaviors, thoughts, and emotions that disrupt life and relationships. **OCPD** is about an excessive need for orderliness and control. It can be perceived as extreme perfectionism, stubbornness, and inflexibility. A rigid adherence to rules, details, order, and schedules prevents someone living with **OCPD** from fully living life and participating fully in relationships.

~~from *HealthyPlace.com*

You Can Be Self-Confident When You Live with Mental Illness

"Believe in yourself," they say. If you live with a mental health disorder, you might have well-meaning friends and family members who try to encourage you.

Yet the nature of mental health disorders can make it difficult to have self-confidence. It's hard to feel sure of yourself when mental illness looms over you. Mental illness in general

- makes you question yourself, wondering if you're thoughts and feelings are "normal"
- zaps your energy, making you feel "lazy" or "worthless"
- interferes in your ability to take actions you want to take.

These are a few ways in which mental disorders interfere with self-confidence. Despite these things, you can believe in yourself and act with confidence. Try these tips:

- "When you find yourself questioning your thoughts, acknowledge them, but don't get stuck there. Examine your goals and things you can do to achieve them regardless of what your thoughts are telling you.
- Drop labels like "lazy" and "worthless." Focus on self-care, including rest, exercise, and nutrition.
- Know what's important to you, and define goals accordingly. Then, create an action plan that involves taking small steps every day to achieve it.

Mental illness can affect your life, but you can move forward and live well despite it. It is this that hones self-confidence.

~~from *HealthyPlace.com*

THE CONCEPT OF SCHIZOPHRENIA IS COMING TO AN END - HERE'S WHY

by Simon McCarthy-Jones, *The Conversation*, August 26, 2017

"The syndrome is already beginning to breakdown..."

The concept of schizophrenia is dying. Harried for decades by psychology, it now appears to have been fatally wounded by psychiatry, the very profession that once sustained it. Its passing will not be mourned.

Today, having a diagnosis of schizophrenia is associated with a life-expectancy reduction of nearly two decades. By some criteria, only one in seven people recover.

Despite heralded advances in treatments, staggeringly, the proportion of people who recover hasn't increased over time. Something is profoundly wrong.

Part of the problem turns out to be the concept of schizophrenia itself. Arguments that schizophrenia is a distinct disease have been "fatally undermined".

Just as we now have the concept of autism spectrum disorder, psychosis (typically characterized by distressing hallucinations, delusions, and confused thoughts) is also argued to exist along a continuum and in degrees.

Schizophrenia is the severe end of a spectrum or continuum of experiences.

Jim van Os, a professor of psychiatry at Maastricht University, has argued that we cannot shift to this new way of thinking without changing our language.

As such, he proposes the term schizophrenia "should be abolished". In its place, he suggests the concept of a psychosis spectrum disorder.

Another problem is that schizophrenia is portrayed as a "hopeless chronic brain disease". As a result, some people given this diagnosis, and some parents, have been told cancer would have been preferable, as it would be easier to cure.

Yet this view of schizophrenia is only possible by excluding people who do have positive outcomes. For example, some who recover are effectively told that "it mustn't have been schizophrenia after all".

Schizophrenia, when understood as a discrete, hopeless and deteriorating brain disease, argues van Os, "does not exist".

Breaking down breakdowns

Schizophrenia may instead turn out to be many different things. The eminent psychiatrist Sir Robin Murray describes how:

I expect to see the end of the concept of schizophrenia soon - the syndrome is already beginning to breakdown, for example, into those cases caused by copy number [genetic] variations, drug abuse, social adversity, etc. Presumably this process will accelerate, and the term schizophrenia will be confined to history, like "drosy".

Research is now exploring the different ways people may end up with many of the experiences deemed characteristic of schizophrenia: hallucinations, delusions, disorganized thinking and behavior, apathy and flat emotion.

Indeed, one past error has been to mistake a path for the path or, more commonly, to mistake a back road for a motorway.

For example, based on their work on the parasite *Toxoplasma gondii*, which is transmitted to humans via cats, researchers E. Fuller Torrey and Robert Yolken have argued that "the most important etiological agent [cause of schizophrenia] may turn out to be a contagious cat".

It will not.

Evidence does suggest that exposure to *Toxoplasma gondii* when young can increase the odds of someone being diagnosed with schizophrenia.

However, the size of this effect involves less than a twofold increase in the odds of someone being diagnosed with schizophrenia. This is, at best, comparable to other risk factors, and probably much lower.

For example, suffering childhood adversity, using cannabis, and having childhood viral infections of the central nervous system, all increase the odds of someone being diagnosed with a psychotic disorder (such as schizophrenia) by around two to threefold.

More nuanced analyses reveal much higher numbers.

Compared with non-cannabis users, the daily use of high-potency, skunk-like cannabis is associated with a fivefold increase in the odds of someone developing psychosis.

Compared with someone who has not suffered trauma, those who have suffered five different types of trauma (including sexual and physical abuse) see their odds of developing psychosis increase more than fiftyfold.

Other routes to "schizophrenia" are also being identified. Around 1 percent of cases appear to stem from the deletion of a small stretch of DNA on chromosome 22, referred to as 22q11.2 deletion syndrome.

It is also possible that a low single digit percentage of people with a schizophrenia diagnosis may have their experiences grounded in inflammation of the brain caused by autoimmune disorders, such as anti-NMDA receptor encephalitis, although this remains controversial.

All the factors above could lead to similar experiences, which we in our infancy have put into a bucket called schizophrenia.

One person's experiences may result from a brain disorder with a strong genetic basis, potentially driven by an exaggeration of the normal process of pruning connections between brain cells that happens during adolescence.

Another person's experiences may be due to a complex post-traumatic reaction. Such internal and external factors could also work in combination.

Either way, it turns out that the two extreme camps in the schizophrenia wars - those who view it as a genetically-based neurodevelopmental disorder and those who view it as a response to psychosocial factors, such as adversity - both had parts of the puzzle.

The idea that schizophrenia was a single thing, reached by a single route, contributed to this conflict.

Implications for treatment

Many medical conditions, such as diabetes and hypertension, can be reached by multiple routes that nevertheless impact the same biological pathways and respond to the same treatment.

Schizophrenia could be like this. Indeed, it has been argued that the many different causes of schizophrenia discussed above may all have a common final effect: increased levels of dopamine.

If so, the debate about breaking schizophrenia down by factors that lead to it

would be somewhat academic, as it would not guide treatment.

However, there is emerging evidence that different routes to experiences currently deemed indicative of schizophrenia may need different treatments.

Preliminary evidence suggests that people with a history of childhood trauma who are diagnosed with schizophrenia are less likely to be helped by antipsychotic drugs.

However, more research into this is needed and, of course, anyone taking antipsychotics should not stop taking them without medical advice.

It has also been suggested that if some cases of schizophrenia are actually a form of autoimmune encephalitis, then the most effective treatment could be immunotherapy (such as corticosteroids) and plasma exchange (washing of the blood).

Yet the emerging picture here is unclear. Some new interventions, such as the family-therapy based Open Dialogue approach, show promise for a wide range of people with schizophrenia diagnoses.

Both general interventions and specific ones, tailored to someone's personal route to the experiences associated with schizophrenia, may be needed. This makes it critical to test for and ask people about all potentially relevant causes.

This includes childhood abuse, which is still not being routinely asked about and identified.

The potential for different treatments to work for different people further explains the schizophrenia wars. The psychiatrist, patient or family who see dramatic beneficial effects of antipsychotic drugs naturally evangelically advocate for this approach.

The psychiatrist, patient or family who see drugs not working, but alternative approaches appearing to help, laud these. Each group sees the other as denying an approach that they have experienced to work.

Such passionate advocacy is to be applauded, up to the point where people are denied an approach that may work for them.

What comes next?

None of this is to say the concept of schizophrenia has no use. Many psychi-

atrists still see it as a useful clinical syndrome that helps define a group of people with clear health needs.

Here it is viewed as defining a biology that is not yet understood but which shares a common and substantial genetic basis across many patients.

Some people who receive a diagnosis of schizophrenia will find it helpful. It can help them access treatment. It can enhance support from family and friends.

It can give a name to the problems they have. It can indicate they are experiencing an illness and not a personal failing. Of course, many do not find this diagnosis helpful.

We need to retain the benefits and discard the negatives of the term schizophrenia, as we move into a post-schizophrenia era.

What this will look like is unclear. Japan recently renamed schizophrenia as "integration disorder". We have seen the idea of a new "psychosis spectrum disorder".

However, historically, the classification of diseases in psychiatry has been argued to be the outcome of a struggle in which "the most famous and articulate professor won".

The future must be based on evidence and a conversation which includes the perspectives of people who suffer - and cope well with - these experiences.

Whatever emerges from the ashes of schizophrenia, it must provide better ways to help those struggling with very real experiences.

~~*Simon McCarthy-Jones, Associate Professor in Clinical Psychology and Neuropsychology, Trinity College Dublin*

In Memoriam

NAMI Syracuse extends our sympathy and condolences to Daniel and Joyce Hould and family on the passing of their son Nathan and we thank them for donations made to NAMI Syracuse in Nathan's memory.

Also, our condolences to Margot Paronis and family on the passing of her husband Zimas.

The Link Between Sugar and Depression

- Men consuming more than 67 grams of sugar per day were 23 percent more likely to develop anxiety or depression over the course of five years than those whose sugar consumption was less than 40 grams per day.
- Other studies have also linked high-sugar diets to a higher risk of depression and anxiety, showing a low-sugar diet is an important part of the prevention and treatment of common mental health problems.
- Sugar increases your risk of depression by contributing to insulin and leptin resistance, suppressing BDNF, affecting dopamine, damaging your mitochondria and promoting chronic inflammation.

The Stephen Beck, Jr. Achieving a Better Life Experience (ABLE) Act of 2014

allows those with disabilities to save for **qualified disability expenses** without the risk of losing their benefits from assistance programs like SSI and Medicaid.

NY ABLE is an ABLE program designed specifically for New York residents. NY ABLE accounts give earnings the ability to grow tax-deferred, and allow savings to be withdrawn tax-free for **qualified expenses**. Qualified expenses are any expenses related to an eligible individual's disability.

Have questions? Call:
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YOU CAN'T "PRAY AWAY" A MENTAL HEALTH CONDITION

by Fonda Bryant, July 19, 2017

At times, it's hard to believe that over 22 years ago, I almost took my life due to depression. Being a black female and growing up in the 1960's where black people had way more to deal with than mental health conditions, mental health was never really discussed.

Fast forward to 2017, and it's mind-boggling just how far behind the African-American culture is when it comes to mental health and suicide. There are so many reasons why this is that I could probably write a book on them. However, I'm just going to focus on three:

A Mental Health Condition Means You're "Crazy"

Relentless stigma accompanies mental health conditions. From the words we use - like "crazy," "cray cray," "psycho," "nuts" - to hurtful jokes about people who live with mental health conditions, stigma surrounding mental health in my culture is deep-rooted. But there is no shame in having a mental health condition. The true shame is not getting the treatment you need to have a good life. Let's all use National Minority Mental Health Awareness Month to take the time to learn the facts from the stigmatizing fiction.

African-Americans need to know: A mental health condition is no different than a physical one. Our brains are the most important organ in our bodies and can get sick just like our hearts, lungs and livers. Not only that, you can recover from a mental health condition and lead a healthy life. Further, African-Americans are not immune from mental health conditions, and 5.6% of us die by suicide. Up to about two million (10%) African-American men live with depression.

A Mental Health Condition is a Sign of Weakness

I was going on 35 years old, with no clue that I had clinical depression. I had never been in trouble with the police, didn't smoke, drink or do drugs. But I found myself sitting in the back of a police car on the way to a mental hospi-

tal, and I kept thinking to myself, "What had I done wrong?" When I arrived at the psychiatric hospital and called my mom to let her know where I was, the first thing she said to me spoke volumes: "You just need to be stronger." This is a battle cry for African-Americans.

Getting help for a mental health condition in my culture's eyes is a sign of weakness, a personal flaw - not a legitimate, clinical condition. In fact, 63% of African-Americans believe that a mental health condition is a personal sign of weakness. To be honest, I believe that number is higher. I know when I walked into that mental hospital 22 years ago, I thought it was going to be everything I'd seen on TV and heard my mom talk about. It was neither. As bad as that day was, it was the beginning of me becoming educated about mental health - which was important not just for me, but for my culture and society as a whole.

A Mental Health Condition is "in God's Hands"

According to a recent Gallup survey, African-Americans are the most religious culture in the United States. Our deep-rooted religious beliefs go all the way back to slavery, when religion was the one solid foundation we had during those times. Our ancestors then - like we African-Americans now - lived with depression, anxiety, bipolar and PTSD but back then, there weren't any names for those conditions. Back then, people battling a mental health condition were simply locked up, wandered the streets or even put to death.

With all that my culture had to deal with throughout history, present-day African-Americans feel we don't need help mentally. All we need to do today is the same our ancestors did, which is: "Pray about it. Give it to God." But you wouldn't tell someone with cancer, diabetes or heart problem to just pray about it or give it to God, would you? You'd hopefully say: "You need to see a doctor." But when it comes to mental health in the African-American community, there is very little compassion or empathy.

Don't get me wrong, there's nothing wrong with praying for recovery from a mental health condition, but we still have to be proactive. We can't "pray away" a

mental health condition. We have to get help. And I am living proof of that.

After receiving treatment, I am living proof that as an African-American female, you can have a mental health condition and thrive! I am proud to be an advocate for NAMI Charlotte and even prouder to be on the board on NAMI NC. Join me in stomping out stigma in all cultures!

~~Fonda Bryant is very active in the community bringing awareness to mental health. She has been a volunteer with NAMI Charlotte for over three years and recently was elected to the state board of NAMI NC. She also volunteers with MHA of Central Carolinas and with the AFSP. She speaks to the rookie classes of CMPD, and is vocal about mental health, whether on television, in the newspaper or radio, her passion for mental health knows no boundaries.

American Foundation for Suicide Prevention

Walk to Fight Suicide Out of the Darkness Community Walk

October 7, 2017, Syracuse/Liverpool
Long Branch Park - West Shore Trail
3813 Long Branch Rd., Liverpool, NY
Register at afsp.org/syracuse

Survivor Day International Survivors of Suicide Loss Day

November 18, 2017
Phoenix VFW
70 Couvert Street, Phoenix, NY
Contact: Angela Marotta
angela.marotta@hutamaki.com
315-529-9893

food served, charge/donation

Survivor Day is the one day a year when people affected by suicide loss gather around the world at events in their local communities to find comfort and gain understanding as they share stories of healing and hope.

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- Discounts on publications, promotional items, and registration at NAMI's annual convention, state and local conferences
- Access to exclusive members-only material on NAMI National's website